DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Kidney Centers
Managed Care Plans
Regional Administrators
CSO Administrators

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Memorandum No: 02-70 MAA
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For Information Contact:
1-800-562-6188

Supersedes: 02-46 MAA

Subject: New Reimbursement Methodology for Dialysis Sessions Billed by Free-Standing Kidney Centers

Effective for dates of service on and after September 1, 2002, the Medical Assistance Administration (MAA) will apply the new reimbursement methodology to billings from free-standing kidney centers for dialysis sessions.

What is the new reimbursement methodology?

Effective for dates of service on and after September 1, 2002, MAA will reimburse free-standing kidney centers for providing kidney center services to MAA clients using one of the following payment methods:

- **Composite rate payments** - A payment method in which all standard equipment, supplies, and services are calculated into a blended rate, known as a "composite rate." All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

- **Fee-for-service payments** – The general payment method MAA uses to reimburse for covered medical services when these services are not covered under the composite rate. This methodology uses a maximum allowable fee schedule to reimburse providers.

For a complete description of the new reimbursement methodology and a new fee schedule for free-standing kidney centers, please refer to attached replacement pages 7-10i and 17/18 for MAA's Kidney Center Billing Instructions, dated August 2000.

To obtain MAA's billing instructions and/or numbered memorandums electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

Bill MAA your usual and customary charge.

Coverage

What is covered?

The Medical Assistance Administration (MAA) covers the services listed in the fee schedule of these billing instructions.

What is not covered?

MAA does **NOT** cover the following services under the **Kidney Center Program**:

- Enteral Nutrition - MAA publishes separate billing instructions for these services. Only pharmacies or durable medical equipment (DME) providers may supply medical nutrition products. MAA does not require prior authorization for dialysis clients.
- Personal Care Items - Slippers, toothbrushes, combs, etc.
- Additional Personnel Charges - Payment includes kidney dialysis service charges (only home dialysis assistant/helper services are considered separate).
- Take Home Drugs - Take home drugs must be billed by a pharmacy subject to pharmacy pricing methodology outlined in MAA's Prescription Drug Program Billing Instructions. This includes immunosuppressive drugs after coverage by Medicare has ended.
- Telephone/Telegraph
- Transportation (Covered through the MAA Non-Ambulance Transportation Program only when prior authorized by the MAA-contracted transportation broker.)
- Television/Radio Rentals
- Freight Charges

☞ **Note:** Services that are **NOT** covered by Medicare must be billed on a separate UB-92 claim form. (Do not include noncovered Medicare services on a claim with services that **ARE** covered by Medicare).

Fee Schedule

HCFA Common Procedural Coding System (HCPCS) Codes

HCPCS Codes for Blood Processing Used in Outpatient Blood Transfusions

☞ **Note:** MAA does not reimburse providers for blood and blood derivatives. Reimbursement is limited to blood bank service charges for processing the blood and blood products (refer to WAC 388-550-6500). The HCPCS blood codes listed below must be used to represent the following costs: 1) blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; or 2) costs incurred by a center to administer its in-house blood procurement program. However, these costs must not include any staff time used to administer blood.

HCPCS Procedure Code	Blood Processing for Transfusion	Maximum Allowable Fee
P9010	Blood (whole), for transfusion, per unit	$55.11
P9011	Blood (split unit), specify amount	By Report
P9012	Cryoprecipitate, each unit	26.20
P9016	Red blood cells, leukocytes reduced, each unit	45.53
P9017	Fresh frozen plasma (single donor), each unit	47.82
P9019	Platelets, each unit	By Report
P9020	Platelet rich plasma, each unit	By Report
P9021	Red blood cells, each unit	66.64
P9022	Red blood cells, washed, each unit	20.50
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	By Report
P9031	Platelets, leukocytes reduced, each unit	By Report
P9032	Platelets, irradiated, each unit	By Report
P9033	Platelets, leukocytes reduced, irradiated, each unit	By Report
P9034	Platelets, pheresis, each unit	By Report
P9035	Platelets, pheresis, leukocytes reduced, each unit	By Report
P9036	Platelets, pheresis, irradiated, each unit	By Report
P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	By Report

HCPCS Procedure Code	Blood Processing for Transfusion	Maximum Allowable Fee
P9038	Red blood cells, irradiated, each unit	By Report
P9039	Red blood cells, deglycerolized, each unit	By Report
P9040	Red blood cells, leukocytes reduced, irradiated, each unit	By Report
P9041	Infusion, albumin (human), 5%, 50 ml	By Report
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml	By Report
P9044	Plasma, cryoprecipitate reduced, each unit	By Report
P9045	Infusion, albumin (human), 5%, 250 ml	By Report
P9046	Infusion, albumin (human), 25%, 20ml	By Report
P9047	Infusion, albumin (human). 25%, 50ml	By Report
P9048	Infusion, plasma protein fraction (human), 5%, 250ml	By Report
P9050	Granulocytes, phereis, each unit	By Report

Drugs Codes Allowed by Medicare using Revenue Code 636

Procedure Code	Name of Drug	Admin. Dosage
90657*	Influenza Virus Vaccine, 6-35 months dosage, for intramuscular or jet injection use	
90658*	Influenza Virus Vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use	
90659*	Influenza Virus Vaccine, whole virus, for intramuscular or jet injection use	
90732*	Pneumococcal Polysaccharide Vaccine, 23-Valent, Adult Dosage, For Subcutaneous or Intramuscular Use	
90747*	Immunization, Active: Hepatitis B Vaccine	40 mcg
J0280	Injection, aminophyllin	250 mg
J0285	Amphotericin	50 mg
J0290	Ampicillin Sodium	500mg
J0295	Ampicillin Sodim/Sulbactam sodium	1.5 g
J0360	Injection, hydralazine HCl	20 mg
J0530	Penicillin G procaine	600,000u

* **These are Current Procedural Terminology (CPT™) codes.**

Procedure Code	Name of Drug	Admin. Dosage
J0610	Calcium Glucontate	10ml
J0630	Calcitnonin Salmon	400u
J0635	Calcitriol	1mcg
J0640	Leucovorin Calcium	50 mg
J0690	Cefazolin Sodium	500mg
J0694	Cefoxitin Sodium	1gm
J0696	Ceftriaxone Sodium	250mg
J0697	Cefuroxime Sodium	750mg
J0702	Betamethasone Acetane and Betamehasone Sodium Phosphate	3 mg
J0704	Betamethasone Sodium Phosphate	4 mg
J0710	Cephapirin Sodium	1gm
J0713	Ceftazidime	500 mg
J0745	Codeine Phosphate	30mg
J0780	Prochlorperazine	10mg
J0895	Deferoxamine Mesylate	500mg
J0970	Estradiol Valerate	40mg
J1060	Testosterone Cypionate and Estradiol Cypionate	1 ml
J1070	Testosterone Cypionate	100 mg
J1080	Testosterone Cypionate, 1 cc	200 mg
J1095	Dexamethasone Acetate	8 mg
J1160	Digoxin	.5 mg
J1165	Phenytoin Sodium	50mg
J1170	Hydromorphone	4mg
J1200	Diphenhydramine HCl	50 mg
J1240	Dimenhydrinate	50mg
J1580	Gentamicin Sulfate	80mg
J1630	Haloperidol	5 mg
J1631	Haloperidol Decanoate	50 mg
J1645	Dalteparin Sodium	2500 IU
J1720	Hydrocortisone Sodium Succinate	100mg
J1750	Iron Dextran	50 mg
J1755	Iron Sucrose	20 mg
J1790	Droperidol	5mg
J1800	Propranolol HCl	1 mg
J1840	Kanamycin Sulfate	500mg
J1885	Ketorolac Tromethamine	15 mg
J1890	Cephalothin Sodium	1gm

Procedure Code	Name of Drug	Admin. Dosage
J1940	Furosemide	20mg
J1955	Levocarnitine	1 gm
J1990	Chlordiazepoxide HCl	100 mg
J2060	Lorazepam	2 mg
J2150	Mannitol 25%	50 ml
J2175	Meperidine HCl	100mg
J2270	Morphine Sulfate	10mg
J2275	Morphine Sulfate (sterile solution)	10 mg
J2320	Nandrolone Decanoate	50mg
J2321	Nandrolone Decanoate	100mg
J2322	Nandrolone Decanoate	200mg
J2500	Paricalcitol	5 mcg
J2510	Penicillin G Procaine Aqueous	600,000u
J2540	Penicillin G Potassium	600,000u
J2550	Promethazine HCl	50mg
J2560	Phenobarbital Sodium	120mg
J2690	Procainamide HCl	1gm
J2700	Oxacillin Sodium	250mg
J2720	Protamine Sulfate	10mg
J2765	Metoclopramide HCl	10mg
J2800	Methocarbamol	10 ml
J2915	Sodium Ferric Gluconate Complex in Sucrose Injection	62.5mg
J2920	Methylprednisolone Sodium Succinate	40 mg
J2930	Methylprednisolone Sodium Succinate	125 mg
J2995	Streptokinase	250,000 IU
J2997	Alteplase Recombinant	1 mg
J3000	Streptomycin	1gm
J3010	Fentanyl Citrate	0.1mg
J3070	Pentazocine HCl	30mg
J3120	Testosterone Enanthate	100mg
J3130	Testosterone Enanthate	200mg
J3230	Chlorpromazine HCl	50mg
J3250	Trimethobenzamide HCl	200mg
J3260	Tobramycin Sulfate	80mg
J3280	Thiethylperazine Maleate	10mg
J3301	Triamcinolone Acetonide	10 mg
J3360	Diazepam	5mg

Procedure Code	Name of Drug	Admin. Dosage
J3364	Urokinase	5,000 IU vial
J3365	IV Urokinase	250,000 IU vial
J3370	Vancomycin HCl	500 mg
J3410	Hydorxyzine HCl	25 mg
J3420	Vitamin B-12 Cyanocobalamin	1,000 mcg
J3430	Phytonadione (Vitamin K)	1mg
J3490	Unclassified Drugs **(see note)**	
P9006	Supplies used to administer blood	Acquisition Cost
P9008	IV pump used to administer IV drugs	Acquisition Cost

Note: The National Drug Code (NDC) number must be included in the comments section of the claim form when billing unlisted drug HCPCS code J3490.

Revenue Codes

Revenue Code	Description	9/1/02 Maximum Allowable Fee
	Pharmacy	
250*	Immunosuppressive drugs	By Report
260	Administration of drugs by IV/intra muscular (non-renal related and/or not covered by Medicare).	By Report
	Medical/Surgical Supplies and Devices	
270*	Medical/surgical supplies	$.50/per supply package
	Laboratory	
303	Laboratory, renal patient (home)	By Report
304	Laboratory, non-routine dialysis	By Report

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services will be covered by Medicare at 80%.**

Revenue Code	Description	9/1/02 Maximum Allowable Fee
	Epoetin (EPO) Injections **Note:** When billing with revenue codes 634 and 635, each one unit reported on the claim form represents 1,000 units of EPO given.	
634*	Erythropoietin (EPO) less than 10,000 units	By Report
635*	Erythropoietin (EPO) 10,000 or more units	By Report
	Drugs Requiring Specific Identification	
636*	Drugs requiring detailed coding **(see note)**	See pages 9 - 10c
	EKG/ECG (Electrocardiogram) – Technical Portion Only	
730*	General classification	By Report
	Hemodialysis - Outpatient or Home	
821*	Hemodialysis/composite rate	$197.45/per session
825	Support Services (Home Helper)	By Report
	Peritoneal Dialysis - Outpatient or Home	
831*	Peritoneal dialysis **(Not in combination with 841, 851, and 880)**	$197.45/per session
845	Support Services (Home Helper)	By Report
	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	
841*	CAPD/Composite Rate **(Not in combination with 831, 851, and 880)**	$84.62/per session
845	Support Services (Home Helper)	By Report

☞ **Note:** Revenue code 636 relates to HCPCS codes, so HCPCS codes must be used in Form Locator 44. Providers must use the description of the procedure code and include the correct number of units on the claim form in order to be reimbursed the appropriate amount. For a listing of HCPCS codes to be used with revenue code 636, refer to pages 9-10c of this fee schedule.

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services will be covered by Medicare at 80%.**

Revenue Code	Description	9/1/02 Maximum Allowable Fee
	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home	
851	CCPD/Composite Rate **(Not in combination with 831, 841, and 880)**	$84.62/per session
855	Support Services (Home Helper)	By Report
	Miscellaneous Dialysis	
880	General Classification **(Not in combination with 831, 841, and 851)**	$197.45/per session
881	Ultrafiltration	By Report

Reimbursement

How does MAA reimburse for kidney center services?

MAA reimburses free-standing kidney centers for providing kidney center services to MAA clients using one of the following payment methods:

- **Composite rate payments** - A payment method in which all standard equipment, supplies, and services are calculated into a blended rate, known as a "composite rate." All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

  ✓ A single dialysis session and related services are reimbursed through a single composite rate payment (see "*What does the composite rate include?"* for a detailed description on what is required and paid for in a composite rate payment).

  ✓ The composite rate is:

  - $197.45 per dialysis session for revenue codes 821, 831, and 880; and
  - $84.62 per dialysis session for revenue codes 841 and 851.

- **Fee-for-service payments** – The general payment method MAA uses to reimburse for covered medical services when these services are not covered under the composite rate. This methodology uses a maximum allowable fee schedule to reimburse providers (see "*What items and services are payable through Fee-For-Service?"* for more detail on fee-for-service payments).

- **Limitations on payment** – MAA evaluates requests for covered services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standards of WAC 388-501-0165.

What does the composite rate include?

- All standard equipment, supplies, and services for in-facility and home dialysis are included in the composite rate.

- The following items and services are included in a composite rate payment:

  ✓ Bicarbonate dialysis;
  ✓ Cardiac monitoring;
  ✓ Crash cart usage for cardiac arrest;
  ✓ Suture removal;
  ✓ Dressing changes;
  ✓ Administration of drugs related to treatment;
  ✓ Medically necessary dialysis equipment;
  ✓ All dialysis services furnished by the facility's staff;
  ✓ Routine ESRD related laboratory tests;
  ✓ Home dialysis support services including the delivery, installation, and maintenance of equipment;
  ✓ Purchase and delivery of all necessary dialysis supplies;
  ✓ Staff time used to administer blood;
  ✓ Declotting of shunts and any supplies used to declot shunts;
  ✓ Oxygen and the administration of oxygen;
  ✓ Staff time used to collect specimens for all laboratory tests;
  ✓ Staff time used to administer nonroutine parenteral items; and
  ✓ Parenteral drugs.

- MAA issues a composite rate payment only when all of the above items and services are furnished or available at each dialysis session.

- MAA allows the following number of dialysis sessions:

  ✓ For revenue codes 821, 831, and 880, a maximum of three (3) per week and no more than 14 per month.
  ✓ For revenue codes 841 and 851, a maximum of seven (7) per week and no more than 31 per month.

  Providers may request a limitation extension (LE) if more than 14 sessions per month are medically necessary. Fax LE requests, including reason(s) for medical necessity, to (360) 586-1471.

- If the facility fails to furnish or have available <u>any</u> of the above items, MAA will not pay for any part of the items and services that were furnished.

What items and services are payable through Fee-For-Service?

The following items and services are not included in the composite rate and may be billed on a fee-for-service basis subject to the restrictions or limitations in these billing instructions and other applicable published WAC:

- Drugs related to treatment such as epoetin or iron replacement products.

  ✓ The drug must be prescribed by a physician; and
  ✓ Must meet the rebate requirements described in WAC 388-530-1125.

- Supplies used to administer drugs and blood.

- Blood processing fees.

- Laboratory tests for renal patient or nonroutine dialysis.

☞ **Note:** Staff time for the administration of blood is included in the composite rate.

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How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

When billing electronically, indicate claim type "M" for Outpatient.

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** – Enter 722 or 723 (indicates free-standing ESRO facility).

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Assistance IDentification (MAID) card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birth date.

15. **Patient Sex** – Male or female

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills or HCFA Common Procedural Coding System (HCPCS) code.

46. **Units of Service** - Enter the number of dialysis sessions and/or EPO units for which you are billing.

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** – Enter any noncovered charges pertaining to detail revenue or procedure codes here. (MAA will *categorically deny* these services.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **Provider Number** - Enter the kidney center provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the kidney center to be due from the indicated payer (estimated responsibility less prior payments).

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

59. **Patient's Relationship to Insured A/B/C** – Enter one of the following two-digit codes indicating the relationship of the patient to the identified insured:

Code	Description
01 =	Patient is insured
02 =	Spouse
03 =	Natural child/insured has financial responsibility
04 =	Natural child/insured does not have financial responsibility
05 =	Step child
06 =	Foster child
07 =	Ward of court/patient ward of insured
08 =	Employee/patient employed by insured
09 =	Unknown
10 =	Handicapped dependent
11 =	Organ donor
12 =	Cadaver donor
13 =	Grandchild
14 =	Niece/nephew